Addendum A Figures

Figure 2-2-A-1 Accreditation/Certification Membership Directories

Guide to The Health Care Field

American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611

Directory of Medical Facilities

Health Care Financing Administration (HCFA)
Administrative Service Section
6401 Security Boulevard
Baltimore, MD 21235

Annual List of Accredited Facilities

Joint Commission on Accreditation of Healthcare Organizations (JC)
875 North Michigan Avenue
Chicago, IL 606ll

***The Christian Science Journal* (monthly)**

The Christian Science Publishing Society
One Norway Street
Boston, *MA* 02115

Registered Occupational Therapists

National Board for Certification of Occupational Therapists
800 South Frederick Avenue
Suite 200
Gaithersburg, Maryland 20877-41450
Phone: (301) 990-7979

Figure 2-2-A-2 Program Information Specialized Treatment Facilities Ambulatory Surgical Centers, CHAMPUS Form 758

PROGRAM INFORMATION
SPECIALIZED TREATMENT FACILITIES
AMBULATORY SURGICAL CENTERS

FACILITY NO _____
DATE _____

The information collected will assist the government in determining whether your facility can be considered an approved source of care, for payment purposes, under the Civilian Health and Medical Program of the Uniformed Services *(CHAMPUS)*. The information will also aid the government in assisting CHAMPUS beneficiaries and representatives of the Uniformed Services in locating appropriate sources of care when there is a requirement for specialized care and treatment programs.

1. FACILITY NAME

2. FACILITY ADDRESS

3. IS YOUR FACILITY ADDRESS DIFFERENT FROM YOUR MAILING ADDRESS OR THE ADDRESS WHERE PAYMENTS ARE SENT ?
☐ YES *(INDICATE ADDRESS)*
☐ NO

4. TELEPHONE NUMBER
( )

5. NAME AND TITLE OF CHIEF ADMINISTRATOR

6. ORGANIZATIONAL STRUCTURE: ☐ CORPORATION ☐ PARTNERSHIP
☐ SINGLE OWNER ☐ PUBLIC AGENCY ☐ PROFESSIONAL CORPORATION ☐ GROUP PRACTICE OR ASSOCIATION

7. TYPE OF OWNERSHIP: ☐ CITY ☐ COUNTY
☐ STATE ☐ PRIVATE NOT-FOR-PROFIT ☐ PRIVATE FOR PROFIT

8. FOR ADMISSION OR ACCEPTANCE INTO YOUR PROGRAM ARE THERE RESTRICTIONS BASED ON AN INDIVIDUAL'S RACE,COLOR, OR NATIONAL ORIGIN?
☐ YES ☐ NO

9. AFTER ADMISSION ARE PATIENTS TREATED EQUALLY WITHOUT REGARD TO RACE, COLOR, OR NATIONAL ORIGIN?
☐ YES ☐ NO

10. TOTAL NUMBER OF SURGICAL UNITS IN YOUR FACILITY?

11. INDICATE HOW YOUR FACILITY RESTRICTS ADMISSIONS BY: SEX _____
AGE _____ GEOGRAPHIC AREA _____

12. IS THE COURSE OF TREATMENT FOR ALL PATIENTS PRESCRIBED AND SUPERVISED BY A PHYSICIAN? ☐ YES ☐ NO *(EXPLAIN YOUR ARRANGEMENTS FOR PHYSICIANS SERVICES)*

13. IDENTIFY YOUR PATIENT POPULATION ☐ RESTORATIVE PHASE *(OUTPATIENT)* ☐ OTHER *(SPECIFY)*

14. INDICATE THE SYSTEM(S) USED TO EVALUATE THE FACILITY'S PROGRAM:
CONTRACTUAL EVALUATION AND/OR PROGRAMMATIC CONSULTATION ☐ YES ☐ NO
PROFESSIONAL SERVICES REVIEW ORGANIZATION ☐ PARTICIPATE ☐ DO NOT PARTICIPATE
UTILIZATION REVIEW ☐ ACTIVE ☐ INACTIVE ☐ NONE ☐ N.A
PATIENT REPRESENTATIVE ☐ YES ☐ NO
PATIENT, FAMILY OR STAFF ADVISORY COMMITTEE ☐ ACTIVELY ☐ NOT ACTIVELY

15. NUMBER OF CHAMPUS PATIENTS YOUR FACILITY TREATED DURING THE LAST 12 MONTHS

16. NUMBER OF CHAMPUS PATIENTS YOUR FACILITY REFERRED TO OTHER HEALTH CARE PROVIDERS DURING THE LAST 12 MONTHS

17. PROVIDE THE FOLLOWING ADDITIONAL INFORMATION:

a. If accredited by Accreditation Association for Ambulatory Health Care Inc. (AAAHC), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare/Medicaid, submit the results of the latest on-site visit by any of those three agencies, including the approval letter, list of recommendations, and your written plan of correction on each deficiency/recommendation. Accreditation by one of the above is a prerequisite for CHAMPUS approval.

b. Copy of state or local operating license. If a license is not required for your facility, furnish a statement from an appropriate state or local official establishing that your facility provides services in accordance with provisions of local or state law.

c. Most recent state or local fire and health inspection reports.

d. Schedule of rates and charges for all services. (Would charges for CHAMPUS beneficiaries differ from the charges incurred by others? If so, explain.)

e. A current brochure, pamphlet, etc., describing your overall program.

f. Names and disciplines of all professional staff (indicate full or part-time).

18. NAME OF FACILITY REPRESENTATIVE

19. SIGNATURE

20. DATE

CHAMPUS FORM 758, FEBRUARY 1988

Figure 2-2-A-3 Program Information New Psychiatric Hospital Pending JC Accreditation, OCHAMPUS Form 759

PROGRAM INFORMATION
NEW PSYCHIATRIC HOSPITAL
PENDING JC ACCREDITATION

FACILITY NO. _____

DATE _____

The information collected will assist the government in determining whether your facility can be considered an approved source of care, for payment purposes, under the Civilian Health and Medical Program of the Uniformed Services *(CHAMPUS)*. The information will also aid the government in assisting CHAMPUS beneficiaries and representatives of the Uniformed Services in locating appropriate sources of care when there is a requirement for specialized care and treatment programs.

1. FACILITY NAME

2. FACILITY ADDRESS

3. IS YOUR FACILITY ADDRESS DIFFERENT FROM YOUR MAILING ADDRESS OR THE ADDRESS WHERE PAYMENTS ARE SENT ?

☐ YES *(INDICATE ADDRESS)*

☐ NO

4. TELEPHONE NUMBER

( )

5. NAME AND TITLE OF CHIEF ADMINISTRATOR

6. ORGANIZATIONAL STRUCTURE: ☐ CORPORATION ☐ PARTNERSHIP ☐ SINGLE OWNER ☐ PUBLIC AGENCY ☐ PROFESSIONAL CORPORATION ☐ GROUP PRACTICE OR ASSOCIATION

7. TYPE OF OWNERSHIP: ☐ CITY ☐ COUNTY ☐ STATE ☐ PRIVATE NOT-FOR-PROFIT ☐ PRIVATE FOR PROFIT

8. FOR ADMISSION OR ACCEPTANCE INTO YOUR PROGRAM ARE THERE RESTRICTIONS BASED ON AN INDIVIDUAL'S RACE,COLOR, OR NATIONAL ORIGIN?

☐ YES ☐ NO

9. AFTER ADMISSION ARE PATIENTS TREATED EQUALLY WITHOUT REGARD TO RACE, COLOR, OR NATIONAL ORIGIN?

☐ YES ☐ NO

10. TOTAL NUMBER OF UNITS IN YOUR FACILITY?

11. INDICATE HOW YOUR FACILITY RESTRICTS ADMISSIONS BY:

SEX _____

AGE _____ GEOGRAPHIC AREA _____

12. IS THE COURSE OF TREATMENT FOR ALL PATIENTS PRESCRIBED AND SUPERVISED BY A PHYSICIAN? ☐ YES ☐ NO *(EXPLAIN YOUR ARRANGEMENTS FOR PHYSICIANS SERVICES)*

13. INDICATE THE SYSTEM(S) USED TO EVALUATE THE FACILITY'S PROGRAM:

CONTRACTUAL EVALUATION AND/OR PROGRAMMATIC CONSULTATION ☐ YES ☐ NO

PROFESSIONAL SERVICES REVIEW ORGANIZATION ☐ PARTICIPATE ☐ DO NOT PARTICIPATE

UTILIZATION REVIEW ☐ ACTIVE ☐ INACTIVE ☐ NONE ☐ N.A

PATIENT REPRESENTATIVE ☐ YES ☐ NO

PATIENT, FAMILY OR STAFF ADVISORY COMMITTEE ☐ ACTIVELY ☐ NOT ACTIVELY

14. PATIENT INFORMATION:

NUMBER OF LICENSED BEDS	NUMBER OF PATIENTS DURING THE LAST TWELVE MONTHS	CURRENT PATIENT CENSUS

15. PROVIDE THE FOLLOWING ADDITIONAL INFORMATION:

a. Copy of state or local operating license.

b. A copy of your Medicare Certification Letter.

c. A copy of all correspondence with JCAHO.

d. Most recent state or local fire and health inspection reports.

e. Schedule of rates and charges for all services. *(Would charges for CHAMPUS beneficiaries differ from the charges incurred by others? If so, explain.)*

f. A current brochure, pamphlet, etc., describing your overall program.

16. NAME OF FACILITY REPRESENTATIVE	17. SIGNATURE	18. DATE

CHAMPUS FORM 759, FEBRUARY 1988

Figure 2-2-A-4 Heart Transplantation Centers CHAMPUS Standards and Certification Requirements, OCHAMPUS Form 760

[FI LETTERHEAD]

Dear [ ]

Effective November 7, 1986, CHAMPUS began coverage for services related to heart transplantation. Attached at enclosure 1 is a copy of CHAMPUS policy regarding benefit coverage.

Benefits for heart transplantation are available only if the procedure is performed in a CHAMPUS-approved heart transplantation center. If you are interested in participating in the CHAMPUS Program, it is necessary that you forward a written request along with program information which provides documented evidence of compliance with CHAMPUS standards. In order to facilitate the administrative certification process in obtaining authorization as a Heart Transplantation Program, please provide the information requested at enclosure 2.

Forward the required information to:

[NAME AND ADDRESS OF FI]

If you have any questions or if we can be of assistance to you, call *[NAME AND PHONE NUMBER OF FI CERTIFICATION SPECIALIST]*.

Sincerely,

[NAME AND TITLE]

Enclosures - 2
CHAMPUS Form Letter 760, February 1988

Figure 2-2-A-4 Heart Transplantation Centers CHAMPUS Standards and Certification Requirements, OCHAMPUS Form 760 (Continued)

HEART TRANSPLANTATION CENTERS
CHAMPUS STANDARDS AND CERTIFICATION REQUIREMENTS

I GENERAL INFORMATION

A. State the complete name, address, and telephone number of your facility. (If your mailing address or the address where payment should be sent is different, specify).

B. Chief Administrator's name and title.

C. Provide a description of the organizational structure, including the range of hospital services, the formal relationship to a specific university graduate medical program, and a description of the medical education program.

D. Type of ownership (e.g., city, county, state).

E. Provide copies of your most recent licensure accreditation and certification.

F. Provide a description of the system(s) used to evaluate the Heart Transplantation Program (e.g., utilization review, quality of care reviews, etc.).

II STANDARDS

A.1. ***Standard:*** The center has experts in the fields of cardiology, cardiovascular surgery, anesthesiology, immunology, infectious disease, nursing, social services, and organ procurement to complement the transplant team.

A.2. ***Information and Documentation Required:***

a. The name of the Heart Transplantation Program Chief, Medical Officer/Director.

b. Names of chief professional officers.

c. Listing of all the assigned members of the heart transplantation professional and medical staff in the fields of cardiology, cardiovascular surgery, anesthesiology, immunology, infectious disease, nursing, social services, and organ procurement.

d. The following information on each professional and medical staff member of the heart transplantation program listed, describing:

(1) Role(s) and responsibility(ies).

(2) Professional and medical qualifications inclusive of formal education and specific experiences and training in heart transplantation services or programs.

(3) The specific time commitment and availability of each staff member to the heart transplantation program.

CHAMPUS Form Letter 760, February 1988

Figure 2-2-A-4 Heart Transplantation Centers CHAMPUS Standards and Certification Requirements, OCHAMPUS Form 760 (Continued)

2

(4) Beginning date of employment.

B.1. ***Standard:*** Responsible transplant team members must be certified or board eligible in their respective disciplines.

B.2. ***Information and Documentation Required:***

a. The names of each heart transplant team member and board certification (or eligibility) of each member.

b. The information requested in paragraph A.2.d.

c. Written agreement to report the loss of any key member of the transplant team to the fiscal intermediary.

C.1. ***Standard:*** The center has an active cardiovascular medical and surgical program as evidenced by a minimum of 500 cardiac catheterization and coronary arteriograms and 250 open heart procedures per year.

C.2. ***Information and Documentation Required:*** Documented statistical evidence for the past five years of the number of cardiac catheterizations, coronary arteriograms and open heart procedures performed per year. Please provide statistical summary information which profiles patient treatment and outcomes (age, diagnosis, procedure, outcome, current status).

D.1. ***Standard:*** The center has performed 12 or more heart transplants in each of the two consecutive preceding 12 month periods prior to its application and 12 heart transplants prior to that.

D.2. ***Information and Documentation Required:***

a. Documented evidence of the performance of 12 or more heart transplantations in the two past consecutive years and 12 heart transplants prior to that. Include profile information on each patient (age, sex, etc.), the dates of the procedures, post transplantation medical care and events, outcomes, and patient's current status.

b. Written agreement to report any significant decrease in this experience level to the fiscal intermediary.

E.1. ***Standard:*** The center has a 73 percent acturial survival rate for one year and 65 percent for two years for patients who have had heart transplants since January 1, 1982.

E.2. ***Information and Documentation Required:***

a. The information in D.2.a. above, as requested, must show documented statistical evidence of survival rates.

b. Written agreement to report any significant decrease in these survival rates to the fiscal intermediary.

F.1. ***Standard:*** The center has infectious disease services with both the professional skills and the laboratory resources that are needed to discover, identify, and manage a whole range of organisms.

CHAMPUS Form Letter 760, February 1988

Figure 2-2-A-4 Heart Transplantation Centers CHAMPUS Standards and Certification Requirements, OCHAMPUS Form 760 (Continued)

F.2. ***Information and Documentation Required:*** Program descriptions of the services available, staff resources, laboratory resources and capacity, and relevant policies, procedures, and protocols.

G.1. ***Standard:*** The center has a nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients.

G.2. ***Information and Documentation Required:*** Written description and identification of the nursing hemodynamic support team, providing qualifications, training, date of employment, and on line availability of team members.

H.1. ***Standard:*** The center has pathology resources that are available for studying and reporting the pathological responses of transplantation.

H.2. ***Information and Documentation Required:*** Written policy and documentation which describes pathology resources, availability, and commitment to the heart transplantation program.

I.1. ***Standard:*** The center has legal counsel familiar with transplantation laws and regulations.

I.2. ***Information and Documentation Required:*** Written documentation regarding available legal counsel resources, which provide the qualification and capacity to deal with transplantation laws and regulations.

J.1. ***Standard:*** The center participates in donor procurement program and network.

J.2. ***Information and Documentation Required:***

a. Written policy and procedures regarding donor procurement programs.

b. A program description which identifies resources, formal relationships, and organizational networks of your donor procurement program.

K.1. ***Standard:*** The center systematically collects and shares data on its transplant program.

K.2. ***Information and Documentation Required:*** Evidence regarding the collection and dissemination of statistical transplantation program information.

L.1. ***Standard:*** The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis.

L.2. ***Information and Documentation Required:***

a. Written policies and program procedures of the transplantation candidate's selection process.

b. Identify the team member professional personnel involved in determining transplantation patient suitability, date of employment, qualifications and availability.

M.1. ***Standard:*** The center has extensive blood bank support.

M.2. ***Information and Documentation Required:*** Written evidence which documents the extent and availability of your program blood bank support of your heart transplantation program.

CHAMPUS Form Letter 760, February 1988

Figure 2-2-A-4 Heart Transplantation Centers CHAMPUS Standards and Certification Requirements, OCHAMPUS Form 760 (Continued)

4

N.1. ***Standard:*** The center must comply with applicable state transplant laws and regulations.

N.2. ***Information and Documentation Required:*** Written documentation of compliance with state and local laws and regulations (i.e., licensure, fire safety, equipment, etc).

O.1. ***Standard:*** Governing body and management.

O.2. ***Information and Documentation Required:*** Written descriptions of the program showing the center to be under the control of a governing body or person(s) so functioning, with full legal authority and responsibility for its management and operation; adopting rules and regulations regarding health care and safety of patients, protection of patient's personal and property rights, and the general operation of the center.

III BILLING REQUIREMENTS

In order to participate in the CHAMPUS Program as an authorized heart transplantation program, the center must agree to bill for all services and supplies related to the heart transplantation performed by its staff and also bill for services rendered by the donor hospital following declaration of brain death and submit all charges on the basis of fully itemized bills. Each service and supply must be individually identified. In your application, provide a written statement stipulating your agreement to the aforementioned billing requirements.

CHAMPUS Form Letter 760, February 1988

Figure 2-2-A-5 Liver Transplantation Centers, CHAMPUS Standards and Certification Requirements, CHAMPUS Form 761

(FI LETTERHEAD)

Dear _____

Effective July 1, 1983, CHAMPUS began coverage for services related to liver transplantation. Attached at enclosure 1 is a copy of CHAMPUS policy regarding benefit coverage.

Benefits for liver transplantation are available only if the procedure is performed in a CHAMPUS-approved liver transplantation center. If you are interested in participating in the CHAMPUS Program, it is necessary that you forward a written request along with program information which provides documented evidence of compliance with CHAMPUS standards. In order to facilitate the administrative certification process in obtaining authorization as a Liver Transplantation Program, please provide the information requested at Enclosure 2.

Forward the required information to:

[NAME AND ADDRESS OF FI/CONTRACTOR]

If you have any questions or if we can be of assistance to you, call ***[NAME AND PHONE NUMBER OF FI/CONTRACTOR CERTIFICATION SPECIALIST]***.

Sincerely,

[NAME AND TITLE]

Enclosures - 2
CHAMPUS Form Letter 761, February 1988

Figure 2-2-A-5 Liver Transplantation Centers, CHAMPUS Standards and Certification Requirements, CHAMPUS Form 761 (Continued)

LIVER TRANSPLANTATION CENTERS
CHAMPUS STANDARDS AND CERTIFICATION REQUIREMENTS

I GENERAL INFORMATION

A. State the complete name, address, and telephone number of your facility. (If your mailing address or the address where payment should be sent is different, specify).

B. Chief Administrator's name and title.

C. Provide a description of the organizational structure, including the range of hospital services, the formal relationship to a specific university graduate medical program, and a description of the medical education program.

D. Type of ownership (e.g., city, county, state).

E. Provide copies of your most recent licensure accreditation and certification.

F. Provide a description of the system(s) used to evaluate the Liver Transplantation Program (e.g., utilization review, quality of care reviews, etc.).

II STANDARDS

A.1. ***Standard:*** The center has experts in the fields of hepatology, pediatrics, infectious disease, nephrology with dialysis capability, pulmonary medicine with respiratory therapy support, pathology, immunology, social services, organ procurement, and anesthesiology to complement the transplant team.

A.2. ***Information and Documentation Required:***

a. The name of the Liver Transplantation Program Chief, Medical Officer/Director.

b. Names of chief professional officers.

c. Listing of all the assigned members of the liver transplantation professional and medical staff in the fields of hepatology, pediatrics, infectious disease, nephrology with dialysis capability, pulmonary medicine with respiratory therapy support, pathology, immunology, and anesthesiology.

d. The following information on each professional and medical staff member of the liver transplantation program listed, describing:

(1) Role(s) and responsibility(ies).

(2) Professional and medical qualifications inclusive of formal education and specific experiences and training in liver transplantation services or programs.

CHAMPUS Form Letter 761 February 1988

Figure 2-2-A-5 Liver Transplantation Centers, CHAMPUS Standards and Certification Requirements, CHAMPUS Form 761 (Continued)

2

(3) The specific time commitment and availability of each staff member to the liver transplantation program.

(4) Beginning date of employment.

B.1. ***Standard:*** Responsible transplant team members must be certified or board eligible in their respective disciplines.

B.2. ***Information and Documentation Required:***

a. The names of each liver transplant team member and board certification (or eligibility) of each member.

b. Written agreement to report the loss of any key member of the transplant team to the fiscal intermediary.

C.1. ***Standard:*** The center has at least a 50 percent one-year survival rate for a minimum of ten cases..

C.2. ***Information and Documentation Required:***

a. Documented statistical evidence that aminimum of ten liver transplants have been performed and that at least 50 percent of the transplant patients have survived one year following surgery.

b. Written agreement to report any significant decrease in this experience level and/or survival rate to the fiscal intermediary.

D.1. ***Standard:*** The center participates in donor procurement program and network..

D.2. ***Information and Documentation Required:***

a. Written policy and procedures regarding donor procurement programs.

b. A program description which identifies resources, formal relationships and organizational networks of your donor procurement program..

E.1. ***Standard:*** The center systematically collects and shares data on its transplant program.

E.2. ***Information and Documentation Required:*** Evidence regarding the collection and dissemination of statistical transplantation program information.

F.1. ***Standard:*** The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis.

F.2. ***Information and Documentation Required:***

a. Written policies and program procedures of the transplantation candidate selection process.

b. Identify the team member professional personnel involved in determinng transplantation patient suitability, date of employment, qualifications, and availability.

Figure 2-2-A-5 Liver Transplantation Centers, CHAMPUS Standards and Certification Requirements, CHAMPUS Form 761 (Continued)

3

G.1. ***Standard:*** The center has sufficient operating room, recovery room, laboratory, radiology, blood bank support, and a sufficient number of intensive care and general surgical beds and specialized staff for these areas.

G.2. ***Information and Documentation Required:*** Written evidence which documents the extent and availability of these services in support of your liver transplantation program.

H.1. ***Standard:*** The center must comply with applicable state transplant laws and regulations.

H.2. ***Information and Documentation Required:*** Written documentation of compliance with state local laws and regulations (i.e., licensure, fire safety, equipment, etc.).

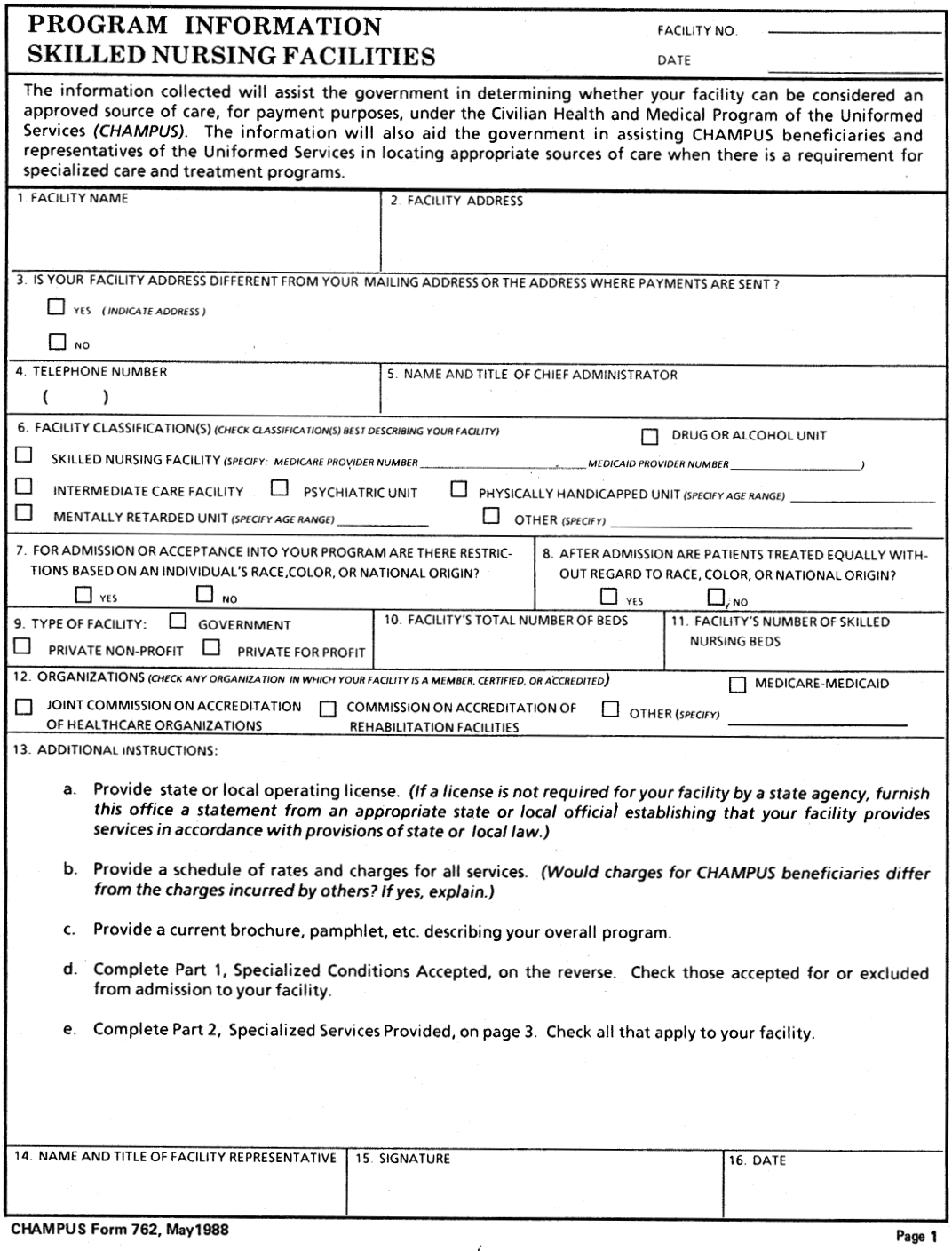
I.1. ***Standard:*** The center incorporates a governing body and management.

I.2. ***Information and Documentation Required:*** Written descriptions of the program showing the center to be under the control of a governing body or person(s) so functioning, with full legal authority and responsibility for its management and operation; adoption of rules and regulations regarding health care and safety of patients, protection of patient's personal and property rights, and the general operation of the center.

III BILLING REQUIREMENTS

In order to participate in the CHAMPUS Program as an authorized liver transplantation program, the center must agree to bill for all services and supplies related to the liver transplantation performed by its staff and also bill for services rendered by the donor hospital following declaration of brain death and submit all charges on the basis of fully itemized bills. Each service and supply must be individually identified. In your application, provide a written statement stipulating your agreement to the aforementioned billing requirements.

Figure 2-2-A-6 Program Information Skilled Nursing Facilities, CHAMPUS Form 762



PROGRAM INFORMATION
SKILLED NURSING FACILITIES

FACILITY NO. _____
DATE _____

The information collected will assist the government in determining whether your facility can be considered an approved source of care, for payment purposes, under the Civilian Health and Medical Program of the Uniformed Services *(CHAMPUS)*. The information will also aid the government in assisting CHAMPUS beneficiaries and representatives of the Uniformed Services in locating appropriate sources of care when there is a requirement for specialized care and treatment programs.

1. FACILITY NAME

2. FACILITY ADDRESS

3. IS YOUR FACILITY ADDRESS DIFFERENT FROM YOUR MAILING ADDRESS OR THE ADDRESS WHERE PAYMENTS ARE SENT ?

☐ YES *(INDICATE ADDRESS)*

☐ NO

4. TELEPHONE NUMBER
( )

5. NAME AND TITLE OF CHIEF ADMINISTRATOR

6. FACILITY CLASSIFICATION(S) *(CHECK CLASSIFICATION(S) BEST DESCRIBING YOUR FACILITY)*

☐ DRUG OR ALCOHOL UNIT

☐ SKILLED NURSING FACILITY *(SPECIFY: MEDICARE PROVIDER NUMBER _____ MEDICAID PROVIDER NUMBER _____)*

☐ INTERMEDIATE CARE FACILITY ☐ PSYCHIATRIC UNIT ☐ PHYSICALLY HANDICAPPED UNIT *(SPECIFY AGE RANGE)* _____

☐ MENTALLY RETARDED UNIT *(SPECIFY AGE RANGE)* _____ ☐ OTHER *(SPECIFY)* _____

7. FOR ADMISSION OR ACCEPTANCE INTO YOUR PROGRAM ARE THERE RESTRICTIONS BASED ON AN INDIVIDUAL'S RACE,COLOR, OR NATIONAL ORIGIN?

☐ YES ☐ NO

8. AFTER ADMISSION ARE PATIENTS TREATED EQUALLY WITHOUT REGARD TO RACE, COLOR, OR NATIONAL ORIGIN?

☐ YES ☐ NO

9. TYPE OF FACILITY: ☐ GOVERNMENT ☐ PRIVATE NON-PROFIT ☐ PRIVATE FOR PROFIT

10. FACILITY'S TOTAL NUMBER OF BEDS

11. FACILITY'S NUMBER OF SKILLED NURSING BEDS

12. ORGANIZATIONS *(CHECK ANY ORGANIZATION IN WHICH YOUR FACILITY IS A MEMBER, CERTIFIED, OR ACCREDITED)*

☐ MEDICARE-MEDICAID

☐ JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS ☐ COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES ☐ OTHER *(SPECIFY)* _____

13. ADDITIONAL INSTRUCTIONS:

a. Provide state or local operating license. *(If a license is not required for your facility by a state agency, furnish this office a statement from an appropriate state or local official establishing that your facility provides services in accordance with provisions of state or local law.)*

b. Provide a schedule of rates and charges for all services. *(Would charges for CHAMPUS beneficiaries differ from the charges incurred by others? If yes, explain.)*

c. Provide a current brochure, pamphlet, etc. describing your overall program.

d. Complete Part 1, Specialized Conditions Accepted, on the reverse. Check those accepted for or excluded from admission to your facility.

e. Complete Part 2, Specialized Services Provided, on page 3. Check all that apply to your facility.

14. NAME AND TITLE OF FACILITY REPRESENTATIVE

15. SIGNATURE

16. DATE

CHAMPUS Form 762, May1988

Page 1

Figure 2-2-A-6 Program Information Skilled Nursing Facilities, CHAMPUS Form 762 (Continued)

PART 1 - SPECIALIZED CONDITIONS ACCEPTED OR EXCLUDED

(CHECK ALL THAT APPLY TO YOUR FACILITY)

	Condition	Accepted	Excluded
1.	AFFECTIVE DISORDERS		
2.	ADDICTIVE DISORDERS, *OTHER THAN ALCOHOLISM*		
3.	ALCOHOLISM		
4.	AUTISM		
5.	BIRTH DEFECTS		
6.	BLINDNESS, *TOTAL*		
7.	BLINDNESS, *PARTIAL*		
8.	BRAIN DAMAGE/DYSFUNCTION		
9.	CEREBRAL PALSY		
10.	CHARACTER AND BEHAVIOR DISORDERS, *MILD*		
11.	CHARACTER AND BEHAVIOR DISTORDERS, *SEVERE*		
12.	CONVULSIVE DISORDERS		
13.	CYSTIC FIBROSIS		
14.	DEAFNESS, *TOTAL*		
15.	DEAFNESS, *PARTIAL*		
16.	DIABETES		
17.	EPILEPSY		
18.	HEMIPLEGIA		
19.	HOMICIDAL TENDENCIES		
20.	HOMOSEXUALITY, *OVERT*		
21.	HOMOSEXUAL TENDENCIES		
22.	LEARNING DISABILITIES		
23.	MENTAL RETARDATION, *MILD*		
24.	MENTAL RETARDATION, *MODERATE*		
25.	MENTAL RETARDATION, *SEVERE*		
26.	MENTAL RETARDATION, *PROFOUND*		
27.	MINIMAL BRAIN DYSFUNCTION AND RELATED DISORDERS		

	Condition	Accepted	Excluded
28.	MULTIPLE SCLEROSIS		
29.	MUSCULAR DYSTROPHY		
30.	NEUROLOGICAL DISEASES		
31.	NEUROSES		
32.	NON-AMBULATORY PATIENTS		
33.	ORGANIC BRAIN SYNDROME		
34.	PARALYSIS		
35.	PARANOID STATES		
36.	PARAPLEGIA		
37.	PHYSICAL HANDICAPS, *MODERATE*		
38.	PHYSICAL HANDICAPS, *SEVERE*		
39.	PSYCHOGENIC DISORDERS		
40.	PSYCHOSES, *BORDERLINE*		
41.	PSYCHOSES, *MODERATE*		
42.	PSYCHOSES, *SEVERE*		
43.	QUADRIPLEGIA		
44.	RUNAWAY TENDENCIES		
45.	SCHIZOPHRENIA, *BORDERLINE*		
46.	SCHIZOPHRENIA, *MODERATE*		
47.	SCHIZOPHRENIA, *SEVERE*		
48.	SEXUAL DEVIATION		
49.	SOCIAL MALADJUSTMENT		
50.	SPEECH DISORDERS/DEFECTS		
51.	SUICIDAL TENDENCIES		
52.	TRANSIENT SITUATIONAL DISTURBANCES		
53.	TUBERCULOSIS		
54.	OTHER *(DESCRIBE ON REVERSE OF PAGE 3)*		

CHAMPUS Form 762, May 1988 Page 2

Figure 2-2-A-6 Program Information Skilled Nursing Facilities, CHAMPUS Form 762 (Continued)

PART 2 - SPECIALIZED SERVICES PROVIDED

(CHECK ALL SERVICES YOUR FACILITY PROVIDES)

- ☐ 1. ART THERAPY
- ☐ 2. AUDIOLOGY/AUDIOMETRY
- ☐ 3. BEHAVIOR MODIFICATION
- ☐ 4. CAMPING PROGRAM, *SPECIAL*
- ☐ 5. CHEMOTHERAPY
- ☐ 6. CLOSED SETTING, *PSYCHIATRIC*
- ☐ 7. CUSTODIAL CARE
- ☐ 8. DANCE THERAPY
- ☐ 9. DELINQUENT CHILDREN'S SERVICES
- ☐ 10. DETOXIFICATION SERVICES
- ☐ 11. DIAGNOSIS AND EVALUATION
- ☐ 12. DOMAN-DELACATO PROGRAM
- ☐ 13. EDUCATION, *FORMAL*
- ☐ 14. EDUCATION, *REMEDIAL*
- ☐ 15. ELECTRONCONVULSIVE THERAPY
- ☐ 16. FAMILY THERAPY
- ☐ 17. GROUP HOME(S), *PSYCHIATRIC*
- ☐ 18. HOSPITAL SERVICES, *COMPLETE*
- ☐ 19. MEDICAL CARE, *INTENSIVE*
- ☐ 20. MILIEU THERAPY
- ☐ 21. MUSIC THERAPY
- ☐ 22. NURSING SERVICE, *PART-TIME*
- ☐ 23. NURSING SERVICE, *SKILLED*
- ☐ 24. NURSING SERVICE, *24-HOUR*
- ☐ 25. OCCUPATIONAL THERAPY
- ☐ 26. OPEN SETTING, *PSYCHIATRIC*
- ☐ 27. PERCEPTUAL MOTOR THERAPY
- ☐ 28. PHYSICAL THERAPY
- ☐ 29. PSYCHIATRIC SERVICE, *COMPLETE*
- ☐ 30. PSYCHIATRIC SERVICE, *INTENSIVE*
- ☐ 31. PSYCHIATRIC SERVICE, *CONSULTING*
- ☐ 32. PSYCHOLOGICAL SERVICE, *COMPLETE*
- ☐ 33. PSYCHOLOGICAL SERVICE, *CONSULTING*
- ☐ 34. PSYCHOTHERAPY, *GROUP*
- ☐ 35. PSYCHOTHERAPY, *INDIVIDUAL*
- ☐ 36. RECREATION THERAPY
- ☐ 37. REFERRAL SERVICES
- ☐ 38. REHABILITATION SERVICES
- ☐ 39. SCHOOL FOR THE DEAF, *ORAL*
- ☐ 40. SCHOOL FOR THE DEAF, *OTHER*
- ☐ 41. SHELTERED WORKSHOP
- ☐ 42. SOCIAL WORK SERVICE
- ☐ 43. SPEECH THERAPY
- ☐ 44. SUMMER PROGRAM, *SPECIAL*
- ☐ 45. TRANSITIONAL SERVICES FOR THE RETARDED
- ☐ 46. TRANSITIONAL SERVICES, *PSYCHIATRIC*
- ☐ 47. TRANSPORTATION
- ☐ 48. UNWED MOTHERS SERVICE
- ☐ 49. VISUAL MOTOR THERAPY
- ☐ 50. VOCATIONAL THERAPY
- ☐ 51. OTHER *(DESCRIBE ON REVERSE)*

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Figure 2-2-A-7 VA Request for an Exception

Manager, *TRICARE* Provider Certification
(Appropriate TRICARE Claims Processors's Address)

Dear Manager:

The Director, *TRICARE Management Activity* (*TMA*), has authorized exceptions, on a case-by-case basis, to the *TRICARE* policy which excludes any civilian employee of the Department of Veterans Affairs (VA) from authorization as a *TRICARE* provider. This letter identifies the individual VA employee(s) for whom an exception is requested based on my determination that an exception is required to avoid a detrimental effect on VA's ability to obtain the necessary **part-time physician employee(s)** essential to the mission of this facility. By granting this exception, the individual part-time physician employee will be an authorized *TRICARE* physician and may file claims for services furnished in the physician's private, non-VA employment practice.

A request for an exception to *TRICARE* policy is made for the following part-time VA physician employee(s):

(List each physician's name, specialty, address, and the physician's IRS/SSAN or other identification number used to report income to the Internal Revenue Service.)

In support of this request for exception to policy, the individual physician(s) named have signed the attached certification, as part of the physician's application for authorization as a *TRICARE* provider, that:

1. The physician understands the prohibitions against dual compensation under Title 5, United States Code, Section 5536, as well as the standards of conduct provisions applicable to Government employees who require the avoidance of actual conflict of interest situations as well as situations in which the appearance of conflict of interest may exist; and

2. The physician has not violated the dual compensation or standard of conduct provisions in providing any services(s) for which a *TRICARE* claim is submitted for payment. This certification shall be retained on file by the *TRICARE* claims processor and be applicable to all claims for services of the physician during the period of authorization as a *TRICARE* provider under this requested exception. In addition, when filing individual *TRICARE* claims, the physician shall annotate the signature block (block 33) of the *TRICARE* claims form with the words "additional certification on file" in order to identify the claim as an exception to the general *TRICARE* policy and confirming that the certification on file applies specifically to that claim.

Figure 2-2-A-7 VA Request for an Exception (Continued)

By requesting an exception to *TRICARE* policy, I agree that the administrators of this VA facility shall assume full responsibility for informing the above-named part-time physician employee(s) of the dual compensation and standard of conduct provisions and for monitoring the conduct of the employee(s) and enforcing the provisions regarding any *TRICARE* claims for service furnished by the employee(s) while acting under this request for exception to policy. In addition, for the above-named part-time physician employee(s), I agree to provide the appropriate *TRICARE* claims processor written notice of termination of VA employment or any other basis for withdrawal of this request for exception to *TRICARE* policy.

Thank you for your prompt attention to this request. Should there be a need to contact VA regarding this request or regarding any matter arising out of the implementation of this request, my point of contact on this matter is _____ who may be contacted at the above address or by telephone number _____.

Sincerely,

VA Facility Administrator

Enclosure:
Physician's Certification

Figure 2-2-A-8 Provider Certification, Department of Veterans Affairs Part-Time Physician Employee

I certify that I am a part-time physician employee of the Department of Veterans Affairs (VA) at ***(Name of VA Facility)*** for whom a letter by the VA facility administrator has requested an exception to the *TRICARE* policy excluding any civilian employee of the Department of Veterans Affairs (VA) from authorization as a *TRICARE* provider. Based on the exception granted to me, I will be authorized as a *TRICARE* provider for services furnished in my private, non-VA employment physician practice. All *TRICARE* claims for services furnished by me under this exception shall be subject to the standard *TRICARE* provider certification except that I am a part-time civilian employee of the United States Government.

I certify that for all such *TRICARE* claims that:

1. I understand the prohibitions against dual compensation under Title 5, United States Code, Section 5536, as well as the standards of conduct provisions applicable to Government employees which require the avoidance of actual conflict of interest situations as well as situations in which the appearance of conflict of interest may exist; and

2. I have not violated the dual compensation or standard of conduct provisions in providing a service(s) for which a *TRICARE* claim is submitted for services furnished by me.

When any *TRICARE* claim is filed, I agree to annotate the signature block on the claim form with the words, “additional certification file,” in order to identify the claim as an exception to the general *TRICARE* policy and confirming that this certification maintained on file by the *TRICARE* claims processor as part of my provider file applies specifically to each claim filed.

_____

(Typed Physician’s Name, Address, and Identification Number)

Figure 2-2-A-9 Contractor UPIN Transition Monthly Workload Report

Contractor Name: _____ *Contract Number:* _____

Report for (check one or more):

____ *Initial Batch Submission* ____ *Initial Batch Registry Response*
____ *Weekly Batch Submission* ____ *Weekly Batch Registry Response*

Initial Batch Submission:

1. *Total Number of Records Submitted* _____
2. *Number of Individual Provider Records Submitted* _____
3. *Number of MD Provider Records Submitted* _____
4. *Number of DO Provider Records Submitted* _____
5. *Number of Other Provider Records Submitted* _____
6. *Number of Group Records Submitted* _____
7. *Date Records Submitted (Mailed)* _____

Initial Batch Response:

1. *Total Number of Records In Response Tapes* _____
2. *Number of Individual Provider Records In Response* _____
3. *Number of New Individual Provider Records Added to Registry/UPINs Assigned* _____
4. *Number of New MD Records Added to Registry/UPINs Assigned* _____
5. *Number of New DO Records Added to Registry/UPINs Assigned* _____
6. *Number of New Other Provider Records Added to Registry/ UPINs Assigned* _____
7. *Number of Individual Provider Records Matched* _____
8. *Number of MD Provider Records Matched* _____
9. *Number of DO Provider Records Matched* _____
10. *Number of Other Provider Records Matched* _____
11. *Number of Individual Provider Records Possible Match* _____
12. *Number of MD Provider Records Possible Match* _____
13. *Number of DO Provider Records Possible Match* _____
14. *Number of Other Provider Records Possible Match* _____
15. *Number of Individual Provider Records Not Matched* _____
16. *Number of MD Provider Records Not Matched* _____
17. *Number of DO Provider Records Not Matched* _____
18. *Number of Other Provider Records Not Matched* _____
19. *Number of Group Records In Response Tapes* _____
20. *Number of Group Records Matched* _____
21. *Number of Group Records Possible Match* _____
22. *Number of Group Records Not Matched* _____
23. *Date Records Received From Registry* _____

Figure 2-2-A-9 **Contractor UPIN Transition Monthly Workload Report (Continued)**

Weekly Batch Submission:

1. *Total Number of Records Submitted* _____
2. *Number of Individual Provider Records Submitted* _____
   - **a.** *Number of Records: First Time Submissions* _____
   - **b.** *Number of Records: Confirmations/Resolutions* _____
3. *Number of MD Provider Records Submitted* _____
   - **a.** *Number of Records: First Time Submissions* _____
   - **b.** *Number of Records: Confirmed Match* _____
   - **c.** *Number of Records: Resolutions* _____
     - **(1)** *Confirmed Match* _____
     - **(2)** *Query for Attempt to Match (data added or corrected)* _____
     - **(3)** *Request for UPIN Assignment* _____
4. *Number of DO Provider Records Submitted* _____
   - **a.** *Number of Records: First Time Submissions* _____
   - **b.** *Number of Records: Confirmed Match* _____
   - **c.** *Number of Records: Resolutions* _____
     - **(1)** *Confirmed Match* _____
     - **(2)** *Query for Attempt to Match (data added or corrected)* _____
     - **(3)** *Request for UPIN Assignment* _____
5. *Number of Other Provider Records Submitted* _____
   - **a.** *Number of Records: First Time Submissions* _____
   - **b.** *Number of Records: Confirmed Match* _____
   - **c.** *Number of Records: Resolutions* _____
     - **(1)** *Confirmed Match* _____
     - **(2)** *Query for Attempt to Match (data added or corrected)* _____
     - **(3)** *Request for UPIN Assignment* _____
6. *Number of Group Records Submitted* _____
   - **a.** *Number of Records: First Time Submissions* _____
   - **b.** *Number of Records: Confirmed Match* _____
   - **c.** *Number of Records: Resolutions* _____
     - **(1)** *Confirmed Match* _____
     - **(2)** *Query for Attempt to Match (data added or corrected)* _____
     - **(3)** *Request for UPIN Assignment* _____
7. *Date Records Submitted (Mailed)* _____

Figure 2-2-A-9 **Contractor UPIN Transition Monthly Workload Report (Continued)**

Weekly Batch Response:

1. *Total Number of Records In Response Tapes* _____
2. *Number of Individual Provider Records In Response* _____
3. *Number of New Individual Provider Records Added to Registry/UPINs Assigned* _____
4. *Number of New MD Records Added to Registry/UPINs Assigned* _____
5. *Number of New DO Records Added to Registry/UPINs Assigned* _____
6. *Number of New Other Provider Records Added to Registry/UPINs Assigned* _____
7. *Number of Individual Provider Records Matched* _____
8. *Number of MD Provider Records Matched* _____
9. *Number of DO Provider Records Matched* _____
10. *Number of Other Provider Records Matched* _____
11. *Number of Individual Provider Records Possible Match* _____
12. *Number of MD Provider Records Possible Match* _____
13. *Number of DO Provider Records Possible Match* _____
14. *Number of Other Provider Records Possible Match* _____
15. *Number of Individual Provider Records Not Matched* _____
16. *Number of MD Provider Records Not Matched* _____
17. *Number of DO Provider Records Not Matched* _____
18. *Number of Other Provider Records Not Matched* _____
19. *Number of Group Records In Response Tapes* _____
20. *Number of New Group Records Added to Registry/ UPINs Assigned* _____
21. *Number of Group Records Matched* _____
22. *Number of Group Records Possible Match* _____
23. *Number of Group Records Not Matched* _____
24. *Date Records Received From Registry* _____
25. *Number of Individual Provider Records Pending Resolution/Enrollment* _____
26. *Number of Group Records Pending Resolution/Enrollment* _____

Figure 2-2-A-10 Contractor OSCAR Transition Workload Report

Contractor Name: _____ *Contract Number:* _____

OSCAR Batch Submission

1. *Total Number of Records Submitted* _____
2. *Number of Hospital Records Submitted* _____
3. *Date Records Submitted (Mailed)* _____